

**KENTUCKY BOARD OF LICENSURE FOR
OCCUPATIONAL THERAPY**

P. O. Box 1360
Frankfort, KY 40602
(502) 564-3296 x226
<http://bot.ky.gov>

2014 ANNUAL OT/OTA RENEWAL APPLICATION

Name _____

Address _____

City _____ State _____

Zip Code _____

☐ Check here if name or address has changed from above.

319A.160 of the Kentucky Revised Statutes requires each licensed occupational therapist and occupational therapy assistant to renew his or her license by October 31st of each year. Your current license will expire **October 31, 2014**. Failure to renew your license shall constitute sufficient cause for termination of licensure. **Licenses not renewed by December 30, 2014 (includes 60 day grace period) will terminate and you are hereby advised at such time you must CEASE AND DESIST the practice of occupational therapy in Kentucky.**

FOLLOW THESE INSTRUCTIONS AND FILL IN ALL BLANKS:

- Complete this form by filling in the information requested below. Incomplete forms **will be** returned.
- Attach the appropriate renewal fee: Forms received without the appropriate fee **will be** returned. ***Make check or money order payable to the Kentucky State Treasurer. DO NOT SEND CASH.***
 - Renewals mailed on or before October 31; (must be postmarked on or before October 31): Active OT -\$50.00; Active OTA - \$35.00; Inactive OT or OTA - \$10.00
 - Renewals mailed November 1 – December 30 - (must be postmarked on or before December 30): Active OT or OTA -\$75.00; Inactive - \$10.00
- Complete the backside of this renewal application for continuing competence unit credit. Each occupational therapist and occupational therapy assistant must complete twelve (12) continuing competence units obtained during the period of November 1, 2013 to October 31, 2014. The board will require documentation of obtained continuing competence units if you are audited. DO NOT attach documentation of continuing competence unless you are requested to do so. **We cannot accept units that have not been earned. You must wait to file your renewal until after all requirements are met.**
- Return this form with your check or money order to the address listed above on or before October 31, 2014. **Any form, which is returned due to incomplete or incorrect information, will be subject to late penalties if not returned by the deadlines stated above.**

TO BE COMPLETED BY ALL LICENSEES, Incomplete forms will be returned: (Please Print)

Name: _____ Social Security # _____ License #: OT _____ OTA _____

Home Address:

Street or Box number	City	State	Zip Code	COUNTY
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Present Business Address:

Name of Company	Street or Box number	City	State	Zip Code
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Home Phone: _____ Business Phone: _____ E-Mail: _____

Have you been charged with, convicted of or pled guilty to a felony since your last renewal of Kentucky license?

- [] Yes (Attach documentation)
[] No

Have you had disciplinary action taken against you or pending against your occupational therapy or occupational therapy assistant license in any other state or jurisdiction since your last renewal?

- [] Yes (Attach documentation, including a certified copy of the final disciplinary action taken against you.)
[] No

Each licensee shall obtain a minimum of twelve (12) continuing competence units during the 2014 annual renewal period. All units shall be in or related to the field of occupational therapy. Each occupational therapist or occupational therapy assistant is responsible for securing documentation to support proof of units completed.

List below the units of continuing competence obtained, INCLUDING COMPLETE DATE AND UNITS COMPLETED. Incomplete forms will be returned. DO NOT attach documentation unless you are audited. It is your responsibility to maintain all documentation.

List Name of Activity & Qualifying Activity # as listed in 201 KAR 28:200	Date(s) M/D/Y Completed	Units Earned 12 Total

Total CC units completed November 1, 2013 to October 31, 2014 = _____
Total CC units completed during current renewal and grace period (November 1, 2013 to December 30, 2014)= _____

If you are a licensed Occupational Therapist please list all Occupational Therapy Assistants that you are the supervisor for. If you are a licensed Occupational Therapy Assistant, please list the name(s) of your current supervisor(s). Please check the box “FT” if they are “Full Time”, or “PT” if they are “Part Time”.

	FT <input type="checkbox"/> PT <input type="checkbox"/>		FT <input type="checkbox"/> PT <input type="checkbox"/>
	FT <input type="checkbox"/> PT <input type="checkbox"/>		FT <input type="checkbox"/> PT <input type="checkbox"/>
	FT <input type="checkbox"/> PT <input type="checkbox"/>		FT <input type="checkbox"/> PT <input type="checkbox"/>
	FT <input type="checkbox"/> PT <input type="checkbox"/>		FT <input type="checkbox"/> PT <input type="checkbox"/>

Please mark the appropriate box:

- ☐ Remaining on active status. **Fee required. (OT \$50/OTA \$35) Continuing Competence Units must be listed above.**
- ☐ Requesting termination. **No fee required. No Continuing Competence Units required.**
- ☐ Requesting an inactive status. **Fee required (OT/OTA \$10). No Continuing Competence Units required.**
REMINDER: Persons on inactive status shall not practice Occupational Therapy KRS 319A.160 (10).
- ☐ Requesting to return to an active status from an inactive status. **Fee required. (OT \$50/OTA \$35) Continuing Competence Units as required by 201 KAR 28:200 Section 2 (3) must be listed above.**
- ☐ Currently on an inactive status. **Fee required. (OT/OTA \$10) No Continuing Education required.**

I hereby certify that all information provided by me on this form is true and complete to the best of my knowledge.
(Signature is required. Forms not signed will be returned and subject to late penalties if not returned by the deadlines stated.)

Signature: _____ Date: _____

AUDIT REVIEW - FOR BOARD MEMBER USE ONLY

Application Approved by: _____ Date: _____
Application Denied by: _____ Date: _____
Resubmitted for review: Approved: ☐ Denied: ☐ By: _____ Date: _____
Comments: _____
